MCLAREN HEALTH PLAN COMMUNITY

INDIVIDUAL HMO – BRONZE SAVER – 0 COST SHARING/NATIVE AMERICAN
SCHEDULE OF COST SHARING

This document is a part of your Certificate of Coverage. It provides information about your financial responsibility with respect to your MHP Community Benefits. Please review the detailed chart below for information specific to each Covered Service. This plan is intended to meet the requirements of a High Deductible Health Plan.

Deductible	Out-of-Pocket Maximum	Pharmacy Deductible
$0 Individual $0 Family	$0 Individual $0 Family	$0 Individual $0 Family

Benefit	In-Network Member Financial Responsibility	Out-of-Network I/T/U Provider Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Preventive Services	$0	Provider Balance Billing	100% - No Coverage
Diabetic Services	$0	Provider Balance Billing	100% - No Coverage
Primary Care Physician (PCP) Office Visits	$0	Provider Balance Billing	100% - No Coverage
Specialist Office Visit (other than Allergy Testing and Allergy Injections)	$0	Provider Balance Billing	100% - No Coverage
Allergy Testing (Non-Injections)	$0	Provider Balance Billing	100% - No Coverage
Allergy Injections	$0	Provider Balance Billing	100% - No Coverage
Immunizations (other than Preventive Care)	$0	Provider Balance Billing	100% - No Coverage
Maternity Care	$0	Provider Balance Billing	100% - No Coverage
Injectable Drugs Provided in the Physician Office	$0	Provider Balance Billing	100% - No Coverage
Emergency Care – Emergency Room	$0	$0	$0
Urgent Care	$0	Provider Balance Billing	Provider Balance Billing
Ground Ambulance	$0	Provider Balance Billing	Provider Balance Billing

Benefit	In-Network Member Financial Responsibility	Out-of-Network I/T/U Provider Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Air Ambulance	$0	$0	$0
Inpatient Hospital Services	$0	Provider Balance Billing	100% - No Coverage
Outpatient Hospital Services	$0	Provider Balance Billing	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	$0	Provider Balance Billing	100% - No Coverage
Organ and Tissue Transplants	$0	Provider Balance Billing	100% - No Coverage
Special Surgical Procedures	$0	Provider Balance Billing	100% - No Coverage
Breast Reconstruction Following Mastectomy	$0	Provider Balance Billing	100% - No Coverage
Skilled Nursing Facility Services	$0	Provider Balance Billing	100% - No Coverage
Home Care Services	$0	Provider Balance Billing	100% - No Coverage
Hospice Care	$0	Provider Balance Billing	100% - No Coverage
Outpatient Mental Health Services	$0	Provider Balance Billing	100% - No Coverage
Inpatient Mental Health Services	$0	Provider Balance Billing	100% - No Coverage
Emergency Mental Health Services	$0	$0	$0
Outpatient Substance Abuse Services	$0	Provider Balance Billing	100% - No Coverage
Inpatient Substance Abuse Services	$0	Provider Balance Billing	100% - No Coverage
Emergency Substance Abuse Services	$0	$0	$0
Outpatient Habilitative Services	$0	Provider Balance Billing	100% - No Coverage
Outpatient Rehabilitation	$0	Provider Balance Billing	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	$0	Provider Balance Billing	100% - No Coverage
Reproductive Care and Family Planning Services	$0	Provider Balance Billing	100% - No Coverage
Pediatric Vision	$0	Provider	100% -

Benefit	In-Network Member Financial Responsibility	Out-of-Network I/T/U Provider Member Financial Responsibility	Out-of-Network Member Financial Responsibility
		Balance Billing	No Coverage
Oral Surgery	$0	Provider Balance Billing	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	$0	Provider Balance Billing	100% - No Coverage
Orthognathic Surgery	$0	Provider Balance Billing	100% - No Coverage
Pain Management	$0	Provider Balance Billing	100% - No Coverage
Approved Clinical Trials	$0 Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	Provider Balance Billing	100% - No Coverage
Cancer Drug Therapy	$0	Provider Balance Billing	100% - No Coverage
Educational Services	$0	Provider Balance Billing	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	$0	Provider Balance Billing	100% - No Coverage

Pharmacy	In-Network Member Financial Responsibility*	Out-of-Network I/T/U Provider Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Tier 1 (Preferred Generic)	$0	Provider Balance Billing	100% - No Coverage
Tier 2 (Preferred Brand)	$0	Provider Balance Billing	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	$0	Provider Balance Billing	100% - No Coverage
Tier 4 (Specialty Drugs)	$0	Provider Balance Billing	100% - No Coverage
Preventive Drugs	$0	Provider Balance Billing	100% - No Coverage

*Specialty Drugs must be filled at an MHP Community Preferred Specialty Pharmacy.